DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service
Rockville, Maryland 20857 Refer to: OHP

INDIAN HEALTH SERVICE CIRCULAR NO. 93-4

Indian Health Service Fiscal Intermediary Quality of Care Screens and Followup Procedures

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1. PURPOSE. This circular describes the policies and procedures of the Indian Health Service (IHS) for managing potential quality of care issues identified through Fiscal Intermediary (FI) screens or edits.

2. BACKGROUND. The IHS contract health services (CHS) program authorizes payment for health care services that the IHS cannot provide through its direct care system. An FI, currently the New Mexico Blue Cross/Blue Shield Insurance Company, pays providers for these services. As part of the payment review process, the FI identifies potential quality of care issues. These issues are identified through the use of sentinel event screens established by the IHS Clinical Advisory Group (CAG). This circular outlines the disposition by the IHS of potential quality of care issues raised by the FI.

3. DEFINITIONS.

   A. Fiscal Intermediary - an organization under contract with the IHS that undertakes to validate and pay CHS claims.

   B. Quality of Care Issue - medical information discovered by the FI during the process of validating and paying medical bills that may reflect upon the standard of care rendered to the IHS beneficiary by the provider.

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c. Managed Care Committee - a committee, established by the Director, to plan, develop, promote, and institute the principles of managed care and assure maximum access to quality health services throughout the IHS.

D. Clinical Advisory Group - A group of four senior IHS physicians appointed by the IHS to review medical care problems identified by the FI, and to act as an advisory group to the IHS on monitoring the quality of medical care provided by the private sector that is paid by the FI.

4. POLICY. This policy applies to all CHS claims paid through the FI.

5. RESPONSIBILITIES.

A. FISCAL INTERMEDIARY.

The FI shall:

(1) Institute a system of editing to allow for the post-payment review of quality of care issues, with direction from the CAG (see 5.A.(4)).

(2) Request appropriate medical records to evaluate the issues, as necessary.

(3) Provide a complete report of the potential quality of care issues to the Clinical Director (CD) and CHS Officer/Manager of the service unit from which the patient was originally referred. At the same time, copies shall be sent to the Chief Medical Officer (CM0) and CHS Officer of the Area involved.

(4) Provide trend reports to each IHS Area and the CAG on at least a semi-annual basis.

B. SERVICE UNIT CLINICAL DIRECTOR.

The CD of the service unit, upon receipt of the report from the FI, shall notify the referring physician, if appropriate, and direct the report to the service unit's quality improvement program. Within 4 weeks after receipt of the report 'from the FI, the CD shall provide a written final or, if necessary, an interim disposition of the quality of care issues to the Area CMO.

c. AREA CHIEF MEDICAL OFFICER

Upon review of the service unit's determination, the Area CM0 shall:

(1) Provie comments to the service unit s needed.

(21 Ensure that the provider in question is informed of the quality of care issue, if appropriate.

(3) Take action in consultation with other appropriate offices within IHS when deemed necessary to resolve the quality of care issues.

(4) Inform the FI Medical Director of the disposition of the issue and of any ction required by the FI.

(5) Report the disposition of the issue to he CAG.

D. CLINICAL ADVISORY GROUP,

The CAG will generally serve as *a* resource and consultation group to assist the Area CM0 and Service Unit CD in making appropriate decisions. The responsibilities of the CAG shall include but not be limited to:

(1) Recommending to the FI a series of indicators (sentinel event screens for quality care) to be used in the FI's claims editing and review process.

(2) Serving as a resource for the development and review of quality of care edits.

(3) Reviewing reports of all quality of care issues and dispositions at least twice a year.

(4) Reporting his/her findings and recommendations once each fiscal year to the Area CMOs, Area CHS Officers, and the Managed Care Committee. The findings of the CAG shall be used to:

a. Assist service units in making appropriate referrals of patients to those providers who render services that meet IHS standards of care.

b. Periodically revise the sentinel screens used by the FL.

c. Identify target areas for quality improvement.

6. REPORTING REQUIREMENTS.

A. The CAG shall provide annual reports to the Associate Director, Office of Health Programs, and the Deputy Director, IHS, concerning quality of care screens performed by the FI.

B. The CAG functions, the service unit and Area followups, and the preparation and review of the annual report are an internal control mechanism to address the Federal Managers Financial Integrity Act requirements to assess risk, implement controls, and prevent fraud, waste, and mismanagement.

7. EFFECTIVE DATE.

This circular is effective upon date of signature.

Michel E. Lincoln
Acting Director